NUMBING THE PAIN

The Link Between Trauma, Posttraumatic Stress Disorder, and Substance Abuse

"The more I drink, the more I won't feel anything. The pain is so bad you just want to die. There is no other way out. If you talk about it, it will hurt too much. So instead, keep it a secret. No one will know."

—A client

By Lisa M. Najavits, PhD

This client lives a terrible but common truth: many survivors of trauma use drugs or alcohol to cope with their pain. Most women and many men in substance abuse treatment have a history of trauma, such as assault, child physical or sexual abuse, rape, natural disaster such as hurricane, car accident, military combat, or life-threatening illness (Najavits, Weiss, & Shaw, 1997).

After experiencing a trauma, many people heal naturally over time. But about one-third develop posttraumatic stress disorder (PTSD) (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). PTSD means staying "stuck" in the trauma, unable to successfully cope and go on with normal life. The person with PTSD suffers a range of emotional problems that are described in detail in the *DSM-IV* (American Psychiatric Association, 1994), including *intrusion* (such images of the trauma that keep coming into mind through nightmares and flashbacks), *avoidance* (a wish to avoid reminders of the event), and *arousal* (intense negative reactions, both physical and psychological, when reminded of the event). Rates of current PTSD among clients in treatment for substance use disorder (SUD) range from 11 percent to 59 percent (Najavits et al., 2003; Najavits et al., 1997). Aside from numbers, the suffering associated with this dual diagnosis can be extreme, including heightened risk for additional co-occurring medical and mental health disorders, associated life problems (such as homelessness, HIV, poverty, suicidality, work and relationship problems), vulnerability to further trauma, and difficulties engaging in treatment (K. T. Brady, Killeen, Saladin, Dansky, & Becker, 1994; D. A. Hien, Nunes, Levin, & Fraser, 2000; Najavits, Gastfriend et al., 1998; Najavits et al., 1997; P. Ouimette & Brown, 2002; P. C. Ouimette, Finney, & Moos, 1999).

Assessment

Assessment of PTSD and SUD presents notable challenges. PTSD is often misdiagnosed or underdiagnosed, both generally (Davidson, 2001) and in substance abuse settings (Dansky, Roitzsch, Brady, & Saladin, 1997). This problem arises from factors such as clients' shame about trauma, clinicians' reluctance to ask about trauma, and a focus on co-occurring diagnoses that may actually be secondary to PTSD for some clients (e.g., major depression). Similarly, in mental health settings, clients' SUD may be misdiagnosed or underdiagnosed. There may also be practical implications of the PTSD and SUD assessment that may lead clients to increase or decrease symptom reporting (secondary gain issues such as monetary compensation for PTSD, regaining custody of a child based on improvement in SUD or other legal concerns). Additionally, substance use or withdrawal may impact PTSD symptoms or impair clients' memory. However, clinical observation suggests that the PTSD diagnosis itself appears quite robust even during substance use or withdrawal (in con-

trast to specific symptoms that may be heightened or diminished) (Najavits, in press). Several suggestions for assessment of PTSD and SUD are as follows (Najavits, in press):

• *Routinely assess for trauma, PTSD, and substance abuse.* For a list of Web sites that offer measures that can be downloaded directly, see (Najavits, in press). Also, the section "assessment" in www.seekingsafety.org provides links to several brief, free, self-report measures that can be downloaded.

• *If a client shows up high or inebriated, delay the assessment.*

• *Provide a supportive yet direct style* to help clients feel safe in revealing both their PTSD and SUD.

• *Ask only minimal information to assess trauma.* For example, if it is known that a client has a history of childhood sexual abuse, for most clinical purposes further details are not needed until much later in treatment (e.g., Who did it? Exactly what did they do? How many times? Did you tell anyone? etc.) Such details may evoke emotions that the client is unprepared to handle.

• *Consider a self-report trauma checklist,* which may be less upsetting for the client than an interview and is also less time-intensive.

• *Give clients feedback about the assessment* if they are interested (e.g., the PTSD and/or SUD diagnosis).

• *Assess for trauma and PTSD even during active substance use or withdrawal,* but plan to reconfirm the diagnosis later (such as after 4-6 weeks of abstinence).

• *In addition to trauma history, also assess for trauma-related symptoms and diagnoses,* such as PTSD.

Counseling models[2]

Several counseling models have been developed specifically for the dual diagnosis and a few have undergone empirical evaluation. Thus far, the bottom line is that all empirical studies of manual-based treatments for PTSD/SUD have shown positive outcomes in trauma-related symptoms, PTSD, SUD, and/or other major variables. Early concerns that addressing trauma or PTSD would worsen substance use do not appear to be borne out, although research remains at an early stage. In addition to studies of specific treatments, a recent major outcome trial, titled Women, Co-Occurring Disorders and Violence (WCDVS), studied more than 2,700 women with co-occurring substance abuse, mental illness, and trauma history at nine sites. Results showed significantly greater improvement in substance use and posttraumatic symptoms for the clients who received trauma-informed interventions than clients who received only treatment-as-usual (Cocozza et al., in press). The four interventions used in that study are described below: *Seeking Safety* (Najavits, 2002), Addictions and Trauma Recovery Integrated Model (Miller & Guidry, 2001), Trauma Recovery and Empowerment (Harris, 1998), and TRIAD (Clark, Giard, & Becker, February, 2003) although separate outcomes for each treatment are not yet available from the WCDVS study.

Models that have been empirically studied

This section describes models designed for the dual diagnosis for which published outcome results are available. In all studies thus far, positive outcomes were found, typically in multiple domains. Citations are provided, but due to space limitations results are not covered in detail here.

Seeking Safety (SS). This is a present-focused therapy to help clients attain safety from both PTSD and SUD. The treatment is available as a book (Najavits, 2002) providing a clinician guide and client handouts. See also the Web site www.seekingsafety.org. It was designed for group or individual format, females and males, and a variety of settings, and has been studied with both adults and adolescents. It offers 25 topics to address cognitive, behavioral, interpersonal, and case management domains: *Introduction/ Case Management, Safety, PTSD: Taking Back Your Power, When Substances Control You, Honesty, Asking for Help, Setting Boundaries in Relationships, Getting Others to Support Your Recovery, Healthy Relationships, Community Resources, Compassion, Creating Meaning, Discovery, Integrating the Split Self, Recovery Thinking, Taking Good Care of Yourself, Commitment, Respecting Your Time, Coping with Triggers, Self-Nurturing, Red and Green Flags, Detaching from Emotional Pain (Grounding), Life Choices,* and *Termination.* SS was designed for flexible use: topics can be conducted in any order, using a few or many topics based on length of stay. It has been implemented by a variety of clinicians (e.g., SUD counselors, social workers, case managers). It is, at this point, the most studied therapy for trauma/PTSD and SUD, with seven completed outcome studies, including two randomized trials. The studies were: outpatient women (Najavits, Weiss, Shaw, & Muenz, 1998); women in prison (Zoricic, Karlovic, Buljan, & Marusic, 2003); low-income urban women (D. Hien, Cohen, Litt, Miele, & Capstick, in press); adolescent girls (Najavits, Gallop, & Weiss, under review); outpatient men, combining SS and Exposure-Therapy Revised (Najavits, Schmitz, Gotthardt, & Weiss, in press); women in a community mental health setting, combining SS and a variety of other manual-based models (Holdcraft & Comtois, 2002); and men and women veterans (Cook, Walser, Kane, Ruzek, & Woody, in press).

Concurrent Treatment of PTSD and Cocaine Dependence (CTPCD). This 16-session, twice weekly individual outpatient psychotherapy was designed for women and men with PTSD and cocaine dependence (Back, Dansky, Carroll, Foa, & Brady, 2001). With some modifications, CTPCD has been used in a variety of settings including inner-city community mental health centers (Coffey, Schumacher, Brimo, & Brady, in press). CTPCD combines imaginal and in vivo exposure therapy for PTSD plus elements of cognitive-behavioral therapy (CBT) for substance dependence (Carroll, 1998; Kadden et al., 1995; Monti, Kadden, Rohsenow, Cooney, & Abrams, 2002). To balance the needs of sobriety skill-building and trauma treatment, the first five sessions focus on coping skills for cocaine dependence. Session six makes the transition

to use of exposure therapy, which begins in session seven, and is combined with a CBT topic for the treatment of substance abuse. One pilot study on CTPCD has been completed (K. Brady, Dansky, Back, Foa, & Caroll, 2001).

Substance Dependence PTSD Therapy (SDPT). SDPT (Triffleman, Carroll, & Kellogg, 1999) is an integration of empirically validated treatment approaches for substance dependence (Carroll, 1998; Carroll, Rounsaville, & Keller, 1991) and trauma (Stress Innoculation Therapy and in vivo exposure). SDPT was designed for both genders and for clients with diverse trauma histories. It is a five-month, twice-weekly individual treatment with two phases. Phase I is "trauma-informed, addiction-focused treatment" and offers five modules derived largely from CBT for substance use (Carroll, 1998; Kadden et al., 1995; Monti et al., 2002): Introduction to SDPT, Coping with Craving and Drug Use Triggers, Relaxation Training, HIV Risk Behaviors, and Anger Awareness and Management. Phase II is a "trauma-focused, addictions-informed phase" to reduce PTSD symptoms while continuing attention to the addiction. The first part of Phase II is a modified version of Stress Innoculation Therapy (SIT) to teach coping skills and cognitive restructuring about trauma-related and other stressful stimuli. In preparation for the in vivo exposure, clients are taught strategies to address avoided situations, such as how to approach and confront them. During the second phase, SIT is combined with in vivo exposure in the form of a desensitization hierarchy. A pilot study is completed (Triffleman, 2000), and a randomized trial is under review (Triffleman, personal communication).

Transcend. Transcend is a 12-week partial hospitalization treatment program for Vietnam veterans with PTSD and SUD (Donovan, Padin-Rivera, & Kowaliw, 2001). It consists of 10 hours per week of group treatment, mandatory attendance in a substance abuse rehabilitation program, and supplementary activities (e.g., volunteer community service). Six weeks focus on skills development, and six weeks on trauma processing, based on a combination of concepts derived from constructivist, existential, dynamic, cognitive-behavioral, and 12-step theory. A pilot study analyzed data on 46 male veterans who completed the Transcend program (Donovan et al., 2001).

Models with empirical results not yet available

The models below do not have published outcome results thus far. However, some were part of the WCDVS study mentioned earlier.

Addiction and Trauma Recovery Integration Model (ATRIUM) (Miller & Guidry, 2001). This 12-week model for individuals and groups integrates CBT and relational treatment to emphasize mind, body, and spiritual health. It provides psychoeducational, process, and expressive activities, including a focus on the body's response to addiction and trauma, anxiety, sexuality, self-harm, depression, anger, physical ailments, sleep difficulties, relationships, and spiritual disconnection.

Helping Women Recover: A Program for Treating Addiction (S.S. Covington, 1999; S. S. Covington, 2000). This treatment integrates theories of women's psychological development, trauma, and

WHAT IS GROUNDING? HOW DOES IT WORK?

Grounding is a set of simple strategies to *detach from emotional pain* (for example, anger, sadness, self-harm impulses, substance cravings). It works by focusing outward on the world, rather than inward toward the self. It can also be called "distraction," "centering," "a safe place," or "healthy detachment." When you are overwhelmed with pain, you need a way to gain control over your feelings and stay safe. Grounding anchors you to the present and to reality. Many people with trauma/PTSD and substance abuse struggle with feeling too much (overwhelming emotion) or too little (numb). In grounding, you attain balance between the two: conscious of reality and able to tolerate it.

- Grounding can be done any time, any place and no one has to know.
- Keep your eyes open, scan the room, and turn the light on to stay in touch with the present.
- Note that grounding is *not* the same as relaxation training or mindfulness (although there is some overlap). Grounding is more active, and is used for a crisis, or flood of negative emotion.

Mental grounding includes the following:

- Describe your environment in detail using all your senses. For example, "The walls are white, there are five pink chairs..." Describe objects, sounds, textures, colors, smells, shapes, numbers, and temperature.
- Play a "categories" game. Name to yourself a list of "types of dogs," "jazz musicians," "states that begin with 'A,'" "cars," "TV shows," "writers," "sports," "songs," etc.

Physical grounding includes the following:

- Run cool or warm water over your hands.
- Touch various objects around you: a pen, keys, your clothing, the table, the walls. Compare objects you touch: Is one colder? Lighter?
- Carry a *grounding object* in your pocket, a small object (a small rock, clay, ring, piece of cloth or yarn) that you can touch whenever you feel triggered.

Soothing grounding includes the following:

- Think of favorites. Think of your favorite color, animal, season, holiday, food, time of day.
- Picture people you care about (e.g., your children).
- Remember the words to an inspiring song, quotation, or poem.
- Say kind statements. For example: "You are a good person going through a hard time. You'll get through this."

Adapted from Najavits (2002, with permission)

addiction treatment to meet the needs of women with SUD. While designed for group modality in residential, outpatient, and inpatient settings, it can be adapted for individual format. It consists of 17 sessions within four modules that women in treatment identify as triggers for relapse: self, relationships, sexuality, and spirituality. The model is published as *Helping Women Recover,* a facilitator's guide and *A Woman's Journal,* a workbook. Versions are also available for incarcerated women. See the Web site www.stephaniecovington.com.

Trauma Adaptive Recovery Group Education and Therapy (TARGET) (Ford, Kasimer, MacDonald, & Savill, 2000). This is a present-focused emotion/information processing and strengths-based approach to skills training for trauma survivors, and can be conducted in individual or group modalities. The goal is to understand how trauma changes the body and brain's normal stress response into an extreme survival-based alarm response that can become PTSD, and to learn a seven-step approach to changing the PTSD alarm response into a less distressing and more adaptive response. TARGET addresses substance abuse and PTSD concurrently in every session, with a focus on addressing PTSD to simultaneously reduce SUD symptoms and prevent relapse. The specifics of clients' traumas are not discussed during the program.

Trauma-Relevant Relapse Prevention Training. This early model (Abueg & Fairbank, 1991; Abueg et al., 1994) was designed for inpatient veterans with PTSD and alcoholism. Based on developmental and social learning models, it offers a framework to understand what has happened, tools for effective coping, an arena to experience the discomfort of previous coping mechanisms, and practice new skills. It has three phases derived in part from the stages of change model (Prochaska et al., 1994). Phase 1 solidifies motivation for change through assessment, education, and interpersonal work. Phase 2 represents the action stage, and incorporates exposure-based therapy in a developmental framework to address trauma issues. Phase 3 emphasizes maintenance and generalization of learning via modified relapse prevention training. Although there has been mention of empirical study of this model (Ruzek, Polusny, & Abueg, 1998), no results have thus far been published.

Treating Addicted Survivors of Trauma. This book (Evans & Sullivan, 1995) provides an integration of therapy and 12-step approaches to the treatment of substance abuse. It is designed for childhood abuse survivors who have SUD and is based on a medical view of substance abuse as illness. It assumes that clients will accept the 12-step approach, it uses the principle of "safety first" as the overall therapeutic strategy, and it has five stages to guide the selection of strategies to promote dual recovery. The stages include crisis, skill building, education, integration, and maintenance.

TRIAD (Clark et al., February, 2003). This 16-week group model for women focuses on six goals: maintaining immediate safety, promoting skill building, maintaining recovery and preventing relapse, assisting women to build on their own strengths, building social supports and interpersonal effectiveness, and enhancing capacity to cope with distress. It derives in part from Dialectical Behavior Therapy (Linehan, 1993).

Other models. Other models are described briefly but have not yet been manualized or empirically studied. These include: group therapy for PTSD and alcohol abuse (Meisler, 1999), a model for inpatient units (Bollerud, 1990), and a brief book (Trotter, 1992). Other models are available for trauma or PTSD, but were not specifically designed for SUD clients, such as Trauma Recovery and Empowerment (Harris, 1998), Eye Movement Desensitization and Reprocessing (Shapiro, 1995), and Exposure Therapy (Foa & Rothbaum, 1998).

General treatment themes

In addition to specific counseling models for PTSD and SUD, some common themes are as follows:

Integrated treatment. It is recommended that clients be treated for PTSD and SUD at the same time. It used to be said that clients needed to attain abstinence from substances before embarking on PTSD treatment ("sequential treatment"). However, all of the specialized treatments designed for the dual diagnosis address both disorders simultaneously, and thus far, their empirical evidence has been positive. Clients too repeatedly express a preference to work on both disorders at the same time (Brown, Stout, & Gannon-Rowley, 1998; Najavits, Sullivan, Schmitz, Weiss, & Lee, in press). However, no studies as yet have specifically compared integrated versus sequential treatment for this dual diagnosis.

Psychoeducation. Clients often have little knowledge of PTSD and its relation to SUD. It can be highly therapeutic to learn about them and how commonly they co-occur. Such psychoeducation can help clients attain a respectful awareness of their symptoms, rather than feeling "crazy, lazy or bad" (Najavits, 2002).

Coping skills. Clients with this dual diagnosis often have poor coping skills. They may not have seen positive coping in their family of origin, and may have diminished coping due to the impact of PTSD and SUD. Poor coping may include substance use, self-harm and suicidality, passivity (letting life just "happen"), and relationship problems such as power struggles. Thus, most treatments designed for this dual diagnosis place a strong emphasis on coping skills.

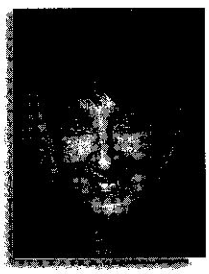
Trauma-informed treatment. In addition to particular counseling models, there is increasing focus on the need for treatment systems to be "trauma-informed" (Fallot & Harris, 2001). Even staff who do not conduct psychotherapy (administrators, support staff) can improve the treatment atmosphere by learning about trauma and PTSD. Typical themes of trauma-informed treatment include: adapting policies to be sensitive to trauma (e.g., letting a client keep the lights on at night in a residential program), creating advanced directives (collaborating with the client to develop a plan for what to do if he becomes agitated), seclusion and restraint policies that do not reenact trauma (e.g., avoiding four-point restraints), and a therapeutic style that takes trauma into account (emphasis on empathy and empowerment).

Multiple treatments. Because this dual diagnosis is complex, with many associated life problems (homelessness, poverty, medical problems, HIV risk, parenting issues, legal problems), the more modalities of treatment, the better. This may include 12-step groups, parent skills training, psychopharmacology, group therapy, day treatment, domestic violence counseling, etc.

Countertransference. Both PTSD and SUD tend to evoke strong countertransference responses (Imhof, 1991; Pearlman & Saakvitne, 1995). These run the gamut from overidentification with clients' suffering (such as secondary traumatization in which clinicians develop PTSD-like symptoms themselves), frustration and anger when clients relapse, power struggles (such as unconsciously recreating the trauma roles of victim, perpetrator, or bystander; Herman, 1992), and boundary lapses such as excessive self-disclosure. Thus, clinicians' ability to manage their emotional responses is a key aspect of successful treatment.

A call for clinical innovation

Helping clients work on both PTSD and SUD is a rewarding, but challenging clinical endeavor. A substantial number of clients have this dual diagnosis, and many have additional co-occurring life problems (e.g. poverty, self-harm, homelessness, HIV risk). This article provides suggestions on assessment and treatment and describes psychotherapies designed for the dual diagnosis. The past decade has seen progress in descriptive studies and outcome studies testing some of the new psychotherapies. However, research remains at an early stage. There are few randomized controlled trials of treatments for this population; and thus far, no published studies have compared integrated treatment versus parallel or sequential models. More research and continued clinical innovation are warranted. ⊙



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Footnotes

[1]Originally quoted in (Najavits, 1996).

[2]This section is drawn in part from the Treatment Improvement Protocol Trauma and Substance Abuse, with permission (Center for Substance Abuse Treatment, in press).

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